PLEASE ALLOW 21 DAYS FOR PROCESSING. ANY MISSING OR INCOMPLETE INFORMATION COULD RESULT IN DELAYS.

AvanceCare

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

For oral communications, please complete the *Avance Care Consent to Verbally Disclose PHI* form

This authorization applies to the entire Avance Care organization, including all primary care services, and behavioral health and wellness specialties.

Section One: Patient Information

I give permission to release the health information of:

LEGAL PATIENT NAME (REQUIRED)	DATE OF BIRTH
ADDRESS	PHONE
EMAIL ADDRESS	MEDICAL RECORD NUMBER (if known)

LEGAL REPRESENTATIVE NAME (*IF NOT PATIENT) RELATIONSHIP TO PATIENT (Parent, Guardian, or Authorized Representative

*If you are not the patient or the parent of a minor patient, you MUST attach documentation of your authority to act on behalf of the patient (Healthcare Agent/Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)

Section Two: Disclosing and Receiving Parties

Release my records **FROM:**

☐ Avance Care (Please list individual location(s) or indicate "All") _____

OR Name/Facility and/or Practice _____ Phone: _____

Address: _____ Fax: _____

Release my information **TO:**

☐ Me, using the contact information above, in the format specified in Section Five.

OR Name/Facility and/or Practice _____ Phone: _____

Address: _____ Fax: _____

Section Three: Scope of Disclosure, Information to be Released

Treatment Dates to include:

☐ All treatment dates **OR** ☐ Dates of service: _____to_____ only (please be specific)

----- Please read this section carefully -----

☐ **Entire Medical Record**, to include all categories listed below, OR

Individual Categories:

- ☐ Behavioral health/mental health records*
- ☐ Psychiatry records
- ☐ Lab/pathology reports
- ☐ Immunization records
- ☐ Allergy notes
- ☐ Procedure notes
- ☐ Imaging reports
- ☐ Nutrition notes
- ☐ Medication list
- ☐ Other: _____

AND/OR ☐ Billing statements (not typically included as part of your medical record)

All types of information found in the records selected to the left will be provided (if applicable), including information that may be viewed as sensitive, such as information related to substance abuse disorder (SUD), genetic information, HIV testing, HIV results or AIDS information. If you do NOT want these categories included in this release, you must clearly indicate that choice here.

Please specify any information you want to exclude:

_____

_____

* This release does not include psychotherapy or SUD counseling notes that are maintained separately for use solely by the treating provider.

Section Four: Purpose of Request

☐ Personal ☐ Transfer of Care ☐ Continuation of Care ☐ Legal ☐ Disability ☐ Worker's Compensation
☐ Billing/Insurance ☐ Other (specify): _____

Section Five: Format and Delivery of Information (Select one option) WE DO NOT ACCEPT CDs or FLASH DRIVES

☐ Mail (paper) ☐ Fax ☐ MyChart/Patient portal** ☐ In-person pick up*** ☐ Email****

** File size may limit what is accessible in the portal. If so, they will be mailed to the address listed on this release.
*** Please allow 21 calendar days for processing. You will be notified when the records are ready to pick up.
**** We encrypt all email communications to safeguard your information. However, please be aware that this is the only measure we can provide to ensure the security of your medical records during transmission. Email remains inherently vulnerable to unauthorized access, and we recommend exercising caution when sharing sensitive information. File size my limit what we can send via email. If so, they will be mailed to the address listed on this release.

Section Six: Effective and Expiration Date(s) of Authorization

This authorization is effective immediately. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to provide a date, event, or condition, this authorization will expire in ninety **(90) days** from the date of signature.

Section Seven: Patient Considerations and Authorization

I understand that:

- I am not required to sign this authorization to receive medical treatment. Refusing to sign will not prevent or affect the care I receive from Avance Care, nor will it prevent Avance Care from seeking payment for services provided.
- I can cancel or revoke this authorization at any time by submitting a written request to the address provided at the top of this form, ATTN: Medical Records. Any revocation will apply only to information not yet released by Avance Care at the time it processes the revocation.
- If the individual or facility receiving this information is not a healthcare provider or medical insurance provider covered by privacy regulations, the information above may be subject to redisclosure. However, records related to substance use disorder treatment that are protected under Federal Confidentiality Rules (42 CFR Part 2) cannot be re-disclosed without my written authorization, unless otherwise permitted by those regulations (except for uses and disclosures for civil, criminal, administrative, or legislative procedures against you).
- I have a right to receive a copy of this form upon request.
- A fee may be charged for providing the requested protected health information. Please visit our website http://www.avancecare.com/medical-records for a list of fees.

I acknowledge that I have read and understand the terms of this authorization and voluntarily provide my consent for the release of my medical records as indicated above.

SIGNATURE OF PERSON GIVING CONSENT OR LEGAL REPRESENTATIVE DATE

PRINT NAME OF PERSON GIVING CONSENT RELATIONSHIP TO INDIVIDUAL (Self*, Parent, Guardian, or Authorized Representative)

A patient (18 years or older) must authorize the release of their own information unless the patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require the minor's authorization.

Notice to Recipient of 42 CFR Part 2 Protected Records

42 CFR Part 2 prohibits unauthorized use or disclosure of these records.